INDIVIDUAL PROVIDER APPLICATION

Revised 10.23.2008

Home Care Referral Registry
Individual Provider Application
(Please call your registry coordinator if you need help completing this form)
1-800-970-5456

Personal Information:

First Name: MI: Last Name:

Date of birth: Social Security No. Male ☐ Female ☐

SSPS Provider Number:

I would like to work for a consumer/employer in the following category: *(Check all that apply)*

☐ Children

☐ People with Developmental Disabilities

☐ People who are elderly

☐ People with Disabilities over 18 years of age

I heard about the registry by: ☐ word of mouth ☐ internet ☐ case manager ☐ newspaper ☐ other

Contact Information:

Home Address: Apt #

City State Zip County:

Mailing address: *(Skip if the same as above)*

Apt #

City State Zip

Home phone: ( ) -

Work phone: ( ) -

Cell phone: Email address:

* Which ***phone*** do you prefer to be contacted at? ☐ Home ☐ Work ☐ Cell

* Which ***method*** do you prefer to by contacted by? ☐ Mail ☐ Phone ☐ Email

Mode of Transportation:

Yes, I have access to a car. ☐

No, I use public transportation. ☐

Yes, I could drive the consumer/employer's car. ☐

Yes, I have a valid driver's license. ☐

RR staff only: date application entered _____

Drivers license No. _____

State _____

License expiration date _____

Insurance Co. _____

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Distance to work:

How far are you willing to travel to work? _____
Number of miles one-way

Language: Which language do you speak, read and write?

Primary language: _____ Secondary language: _____

Provider Services:

I am willing to provide: (Check all that apply)

☐ Routine Care (work for a specific employer on a regularly scheduled basis)

☐ Emergency/Backup (able to respond on short notice to fill-in for a provider who didn't show up)

☐ Relief Care (work on a temporary, pre-arranged basis to relieve the routine provider)

Are you available to be a live-in provider? ☐ Yes

Have you completed DSHS Nurse Delegation training? ☐ Yes

Living Conditions:

Would you work for someone who smokes? ☐ Yes ☐ No ☐ Doesn't matter

Do you smoke? ☐ Yes ☐ No

Are you willing to cook for a special diet? ☐ Yes ☐ No

Are you willing to not use perfumes or fragrances while working? ☐ Yes ☐ No

Will you work in a home with pets? **Dogs** ☐ Yes ☐ No **Cats** ☐ Yes ☐ No

Personal Care Tasks: Are you willing or do you have experience in the following activities?
(You must be physically able to perform all the tasks you selected in this section.)

	Willing to perform	Previous Experience
Dressing and Undressing	☐	☐
Toileting	☐	☐
Bladder and Bowel Care	☐	☐
Personal Hygiene	☐	☐
Bathing	☐	☐
Self-Medication	☐	☐

Eating	☐	☐
Walking from one area to another	☐	☐
Body Care (i.e. exercises, skin care)	☐	☐
Unscheduled care or Protective Supervision	☐	☐
Positioning	☐	☐
Preparing Meals	☐	☐
Essential shopping for healthcare and nutritional needs	☐	☐
Doing Laundry	☐	☐
Doing housework	☐	☐
Transferring to and from bed, chair, toilet, bathtub	☐	☐
Accompany or drive employer to medical appointment	☐	☐
Transport the employer to a essential shopping	☐	☐
Split, stack and carry firewood?	☐	☐
Do you have experience helping someone who has:		**Yes**
Behavioral Issues or Challenging Behaviors?		☐
Developmental Disabilities?		☐
Dementia?		☐
Mental Health Diagnosis?		☐
Cancer?		☐
Diabetes?		☐
Limited Vision?		☐
Multiple Sclerosis?		☐
Paraplegia?		☐
Quadriplegia?		☐
Difficulties Communicating?		☐
Complications related to a Stroke?		☐
Oxygen Support?		☐
Swallowing Problems?		☐
Acute or Chronic Pain?		☐
Autism?		☐

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I am available to work: (Please check all that apply)				
Days of week	**Morning**	**Afternoon**	**Evening**	**Overnight**
Sunday	☐	☐	☐	☐
Monday	☐	☐	☐	☐
Tuesday	☐	☐	☐	☐
Wednesday	☐	☐	☐	☐
Thursday	☐	☐	☐	☐
Friday	☐	☐	☐	☐
Saturday	☐	☐	☐	☐
Training completed (optional) If ***additional space is needed, use the blank space.***				

Type of training:_____ _____
Course title credit hours (optional)

Date completed: _____ Training offered by: _____
Mm/dd/yyyy name of organization

Type of training:_____ _____
Course title credit hours (optional)

Date completed: _____ Training offered by: _____
Mm/dd/yyyy name of organization

Type of training:_____ _____
Course title credit hours (optional)

Date completed: _____ Training offered by: _____
Mm/dd/yyyy name of organization

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Criminal Background check:

- I understand, in order to be a provider listed on the Home Care Quality Authority (HCQA) Referral Registry, that a Washington State Patrol criminal background check must be completed by DSHS.
- I understand, if I have lived in Washington State for less than three years that a FBI finger-print check will also be conducted.
- I understand that HCQA and subcontractors have the legal right to require background checks for placement on the registry and:
    - Repeat a background check every 12 months
    - May decide not to refer providers based on the background check results
    - Must protect the confidentiality of the information received with the exception of sharing the information with a potential consumer/employer or their representatives.

Furthermore ~ regarding my participation on the HCQA Referral Registry:

- I certify under penalty of perjury that all the information provided in this application and its related process is true. I understand that any false information may eliminate my eligibility for participation on the HCQA Referral Registry.
- I understand that my name and phone number may be placed on a list to be given to persons who are seeking assistance in their homes, without further notice.
- I understand that information collected in the interview process may be shared with DSHS or the AAA in order to complete the DSHS Individual Provider Contract.
- I understand the HCQA or subcontractor retains the exclusive right to list, refer with or without comment, suspend or remove an individual provider from the registry.
- I understand that I, as an individual provider, have the right to appeal removal or denial from the registry.
- I understand completing this application and being listed on the Referral Registry **does not guarantee me employment**.
- I understand that my employer is not the HCQA or the subcontractor or Washington state. The consumer is my employer.
- I further understand that the consumer/employer retains the right to hire, supervise and terminate my employment.
- I understand that I may, by written or verbal request, ask that my name be deleted from the HCQA Referral Registry.
- I understand that I must contact my local HCQA contracted office once a month to update or verify that my information on the Registry is accurate. If I do not update my information, my name will not be referred until I confirm the information is correct or an update occurs.
- I understand by signing this document, I release HCQA and any subcontractor from all liability, including payment that may result from employment through use of the Referral Registry.

Signature: _____ Date: _____

Print Name: _____

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[Laws related to the Referral Registry]

RCW 74.39A.250 (1) (d) (i) (ii) (iii) (e)

(1) The authority must carry out the following duties:

(d) Provide assistance to consumers and prospective consumers in finding individual providers and prospective individual providers through the establishment of a referral registry of individual providers and prospective individual providers. Before placing an individual provider or prospective individual provider on the referral registry, the authority shall determine that:

(i) The individual provider or prospective individual provider has met the minimum requirements for training set forth in RCW 74.39A.050;

(ii) The individual provider or prospective individual provider has satisfactorily undergone a criminal background check conducted within the prior twelve months; and

(iii) The individual provider or prospective individual provider is not listed on any long-term care abuse and neglect registry used by the department;

(e) Remove from the referral registry any individual provider or prospective individual provider the authority determines not to meet the qualifications set forth in (d) of this subsection or to have committed misfeasance or malfeasance in the performance of his or her duties as an individual provider. The individual provider or prospective individual provider, or the consumer to which the individual provider is providing services, may request a fair hearing to contest the removal from the referral registry, as provided in chapter 34.05 RCW;